NURSE DELEGATION: CONSENT FOR DELEGATION OF TASKS

RESIDENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH (MM/DD/YYYY)	CLIENT ID NUMBER
FACILITY NAME		FACILITY'S LICENSE NUMBER
CLIENT/FACILITY'S ADDRESS	CITY STATE ZIP CODE	
NAME OF FACILITY OWNER/MANAGER	TELEPHONE NUMBER	FAX NUMBER / E-MAIL ADDRESS

SETTING	RESIDENT DIAGNOSIS	ALLERGIES
☐ Certified Community Residential Program for Developmentally Disabled ☐ Licensed Adult Family Home ☐ Licensed Boarding Home ☐ Private Home		

HEALTH CARE PROVIDER NAME:

NURSING CARE TASK(S) TO BE DELEGATED

☐ MEDICATION ADMINISTRATION (ROUTE)

- ☐ ORAL
- ☐ GASTROSTOMY TUBE
- ☐ TOPICAL (SKIN/NOSE/EAR/EYE)
- ☐ VAGINAL SUPPOSITORY
- ☐ RECTAL SUPPOSITORY
- ☐ ENEMA
- ☐ INHALATION
- ☐ OTHER: _____

☐ OSTOMY CARE

☐ URINARY CATHETERIZATION (CLEAN TECHNIQUE)

☐ GASTROSTOMY FEEDING

☐ OTHER: _____

☐ DRESSING CHANGE (CLEAN TECHNIQUE)

☐ NEBULIZER/OXYGEN

☐ BLOOD GLUCOSE MONITORING

☐ OTHER: _____

I have been informed of the delegated nursing care task(s), the expected results, the possible risks, and the nursing assistant(s) level of training.

_____ I consent to Nursing Assistant(s) performing the nursing task(s) as directed by a Registered Nurse Delegator.
INITIAL

_____ I have previously discussed the course of treatment that results in these nursing tasks with my health care provider and I have consented to that treatment.
INITIAL

VERBAL CONSENT (obtained from): _____ Date: _____

(Written consent required within 30 days of verbal consent)

RESIDENT OR AUTHORIZED REPRESENTATIVE SIGNATURE	TELEPHONE NUMBER	DATE

My signature below indicates that I have assessed this resident and found this/her condition to be stable and predictable. I agree to assume responsibility and accountability for the delegated task(s) and perform the nursing supervision

RN SIGNATURE		
RN LICENSE NUMBER	TELEPHONE NUMBER	DATE:

To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078 Toll Free

COPIES: Original – Record Copy – RN Delegator Copy - Other